Medical Plans Comparison Sheet (Categories F, H, & I)

Category F – Corrections Guild Category H –Corrections Sergeants & Lieutenants Category I – Corrections Support Supervisors

	Regence SC Select $17 Group #10008695	**Regence PPO $200** Group #10008695	**Group Health Options** Group #6432900
Provider Website	www.regence.com	www.regence.com	www.ghc.org
County Website	Click here	Click here	Click here
Customer Service	1-800-962-0301	1-800-962-0301	1- 888-901-4636
24/7 Nurse Line	1-800-267-6729	1-800-267-6729	1-800-297-6877
Plan Booklet	Click here	Click here	Click here
Summary (SBC)	Click here	Click here	Click here
Smoking Cessation	Quit for Life Program	Quit for Life Program	Quit for Life Program
Premium Rates	Click here for premium rates		
Locate a Provider	Click here	Click here	Click here
Description	Preferred Providers (PPO) are Category 1 and are paid at the highest level. Participating Providers (Par) are Category 2 and are paid at the second level of benefits. Category 3 Providers (Non Par) are not contracted and are also in the second level of benefits. Co-pays are waived for Category 3, as there may be balance billing. Not required to get referrals or choose a Primary Care Provider (PCP).		To receive benefits, participants must select a clinic and a Primary Care Provider (PCP) from the provider list, except for self-referral benefits provided below. When you need more specialized care, your PCP will refer you to a specialist or extended network provider.
Alternative Health Care	Naturopaths covered same as physician services. Massage therapy incorporated in existing rehabilitation benefits for physical therapy treatment. Massage treatments at a spa are not a covered benefit. Acupuncture covered 12 visits per year. Chemical dependency covered same as chemical dependency benefits. Smoking cessation not covered.		**Inside Network:** Subject to copy **Outside Network:** $20 co-pay, deductible and coinsurance apply. Naturopathy - self referral to contracted providers for 3 visits per condition, per calendar year. Acupuncture - self referral for up to 8 visits per diagnosis, per calendar year; additional visits if approved. $20 co-pay, deductible applies.
Ambulance	80% after deductible, any recognized provider	80% after deductible, any recognized provider	**Inside Network:** 80%; Options Network initiated non-emergency transfers covered **Outside Network:** 80%
Deductible	**PPO & Par Providers:** None **Non Par:** $200/person, $600/family	$200/person $600/family	**Inside Network:** None **Outside Network:** $200/person, $300/family

Durable Medical Supplies	**PPO:** 80% **Par:** 80% **Non Par:** 80% after deductible	**PPO:** 80% after deductible **Par:** 80% after deductible **Non Par:** 80% after deductible	**Inside Network:** 100% **Outside Network:** 100% after deductible
Emergency Care	**PPO:** $75 co-pay, covered at 100% **Par:** $75 co-pay, 100% **Non Par:** $75 co-pay, 100% after deductible **Co-pay waived if admitted*	**PPO:** $75 co-pay, covered at 90% after deductible **Par:** $75 co-pay, 90% after deductible **Non Par:** $75 co-pay, 90% after deductible **Co-pay waived if admitted*	**In Network:** $75 co-pay waived if admitted **Outside Network:** $100 co-payment waived if admitted **Co-pay waived if admitted*
Eye Exams	Not covered	Not covered	**Inside Network:** $20 co-pay **Outside Network:** Not covered
Hearing Exams	**PPO:** 100%, no co-pay **Par:** 70% **Non Par:** 70% after deductible	Not covered	**Inside Network:** $20 co-pay **Outside Network:** $20 co-pay, 80% after deductible
Home Health Care	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible *130 visits per year*	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible *130 visits per year*	**Inside Network:** 100% when pre-authorized; no limit **Outside Network:** 80% after deductible; no visit limit
Home Visits	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible *130 visits per year*	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible *130 visits per year*	**Inside Network:** Covered within Options Network service areas when prescribed as medically necessary by an Options Network Provider
Hospice Care	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** 100% when provided and coordinated through Options Network approved hospice program **Outside Network:** 80% after deductible
Hospital Services (Room, Board, etc.)	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** 100% **Outside Network:** 80% after deductible
Inpatient Hospital	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** Paid in full **Outside Network:** 80% after deductible
Intensive Care	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** 100% **Outside Network:** 80% after deductible
Maternity	Covered as any other condition *First 21 days of newborn care covered*	Covered as any other condition *First 21 days of newborn care covered*	**Inside Network:** 100%; $20 co-pay **Outside Network:** 80% after deductible
Mental Health Care	**PPO:** $17 co-pay, then 100% **Par:** $17 co-pay, 100% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 90% after deductible **Non Par:** 60% after deductible	**Inside Network:** Inpatient: Covered in full Outpatient: $20 co-pay, deductible applies **Outside Network:** Inpatient: Deductible and coinsurance applies Outpatient: $20 co-pay, deductible and coinsurance applies

Out of Area Benefits	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible **Outside Service Area:** Benefits are the same regardless of your geographic location. To receive the highest benefit level, members utilize the local Blue Cross/Blue Shield providers.	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible **Outside Service Area:** Benefits are the same regardless of your geographic location. To receive the highest benefit level, members utilize the local Blue Cross/Blue Shield providers.	$100 co-pay, 80% after deductible, waived if admitted *Coverage worldwide for emergency*
Out of Pocket Maximums	**PPO & Par:** $2,500/person, $7,500/family **Non Par:** $10,200/person, $30,600/family Includes deductible	**PPO:** $2,700/person, $8,100/family	**Inside Network:** $1,000/member, $2,000/family **Outside Network:** $2,200/member, $4,300/family
Outpatient Hospital	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** $20 co-pay **Outside Network:** $20 co-pay, then 80% after deductible
Outpatient Prescription Drugs	$10 co-pay generic $20 co-pay generic $20 Brand Formulary $40 Brand Formulary $30 Non Formulary $60 Non Formulary **30 day retail supply / 90 day mail order supply**	$10 co-pay generic $20 co-pay generic $20 Brand Formulary $40 Brand Formulary $30 Non Formulary $60 Non Formulary **30 day retail supply / 90 day mail order supply**	**Inside Network:** $15 co-pay up to 30 day supply **Outside Network:** 80% of generic cost unless brand name is medically necessary. or $20 co-pay (whichever is greater); Must use a Med-Impact pharmacy; mail order not available
Outpatient Surgery	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** $20 co-pay **Outside Network:** $20 co-pay, then 80% after deductible
Physician Office Visits	**PPO:** $17 co-pay, 100% **Par:** $17 co-pay, 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** $20 co-pay, 100% coverage **Outside Network:** $20 co-pay, then 80% after deductible
Physicians	**Category 1 & 2 (PPO and Par).** You will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services. **Category 3 (Non Par).** You may be billed for balances beyond any deductible and/or coinsurance (balance billing).	**Category 1 & 2 (PPO and Par).** You will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services. **Category 3 (Non Par).** You may be billed for balances beyond any deductible and/or coinsurance (balance billing).	PCP at Options Network facilities or your choice of any community doctor outside of the network.
Podiatry	**PPO:** $17 co-pay, 100% **Par:** $17 co-pay, 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** $20 co-pay; when medically necessary **Outside Network:** 80% after deductible; when medically necessary

Preventative Care & Physical Exams	**PPO:** 100%, not subject to deductible **Par:** 100% **Non Par:** 70% after deductible Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings, provider counseling for tobacco use cessation, women's contraceptive methods, sterilization procedures, and patient education and counseling services in accordance with any frequency guidelines according to, and as recommended by HRSA, certain services such as screening for gestational diabetes, breast feeding support, supplies and counseling.	**PPO:** 100%, no deductible **Par:** 100%, no deductible **Non Par:** 60% after deductible Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings, provider counseling for tobacco use cessation, women's contraceptive methods, sterilization procedures, and patient education and counseling services in accordance with any frequency guidelines according to, and as recommended by HRSA, certain services such as screening for gestational diabetes, breast feeding support, supplies and counseling.	**Inside Network:** 100% **Outside Network:** Not covered, except for routine mammography services subject to the annual deductible and plan coinsurance. **Well Child Care:** **Inside Network:** 100% **Outside Network:** Not covered **Gynecological Exams** **Inside Network:** $20 co-pay **Outside Network:** Not covered
Radiation Therapy	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** 100% inpatient; Outpatient: $20 co-pay **Outside Network:** 80% after deductible; Outpatient: $20 co-pay, then 80% after deductible
Rehabilitation Therapy	**Inpatient:** 32 days **Outpatient/PPO:** $17 co-pay, then 100% **Par:** $17 co-pay, then 70% **Non Par:** 70% after deductible *55 visits per year; Physician RX required*	**Inpatient:** 32 days **Outpatient/PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible *55 visits per year; Physician RX required*	**Inpatient:** Covered up to 60 days inside/outside network **Outpatient:** $20 co-pay/o 60 visits/condition **Outside Network:** 80% after deductible *Total of combined therapy visits per calendar year*
Skilled Nursing	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible *Limited to 90 days per year*	**PPO:** 90% after deductible **Par:** 90% after deductible **Non Par:** 90% after deductible *Limited to 90 days per year*	**Inside Network:** Covered with advanced authorization by the Options Network for up to 60 days as an appropriate cost-saving alternative to acute care hospitalization **Outside Network:** 80% after deductible for up to 60 days
Spinal Manipulations	**PPO:** $17 co-pay, then 100% **Par:** $17 co-pay, then 70% **Non Par:** 70% after deductible *10 spinal manipulations per calendar year*	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible *10 spinal manipulations per calendar year*	**Inside Network:** $20 co-pay, 10 visits per calendar year **Outside Network:** $20 co-pay, then 80%; 10 visits after deductible *Does not require a referral from Primary Care Physician*
Surgery Anesthesia	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** 100% **Outside Network:** 80% after deductible

Temporomandibular Joint (TMJ) disorders	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** Inpatient: 100% Outpatient: $20 co-pay **Outside Network:** Inpatient: 80% after deductible Outpatient: $20 co-pay, 80% after deductible
Transplant	**PPO:** 100% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available). **Par:** 70% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available). **Non Par:** 70% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available).	**PPO:** 90% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available). **Par:** 60% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available). **Non Par:** 60% with no lifetime max. Requires pre-authorization by plan and 12 month waiting period (time credit available).	Inside Network: Inpatient: 100% Outpatient: $20 co-pay Outside Network: Inpatient: 80% after deductible Outpatient: $20 co-pay, 80% after deductible No lifetime maximum Requires pre-authorization by plan No waiting period
Treatment of Chemical Dependency	**PPO:** 100% **Par:** 100% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 90% after deductible **Non Par:** 60% after deductible	**Inside Network:** Inpatient: Covered in full Outpatient: $20 co-pay, deductible applies **Outside Network:** Inpatient: Deductible and coinsurance apply Outpatient: $20 co-pay, plus deductible and coinsurance
X-Ray/Lab (Includes mammograms)	**PPO:** 100% **Par:** 70% **Non Par:** 70% after deductible	**PPO:** 90% after deductible **Par:** 60% after deductible **Non Par:** 60% after deductible	**Inside Network:** 100% **Outside Network:** 80% after deductible

REMINDER: This is a general outline of medical benefits and not a guarantee of coverage or service. The information is presented in summary form and should be used for general comparison purposes only. For full details, see plan booklets and/or consult with either Regence or Group Health. Provisions of the plan that are calculated on a calendar year basis are deductibles and Out of Pocket Maximums. Each January 1, those calendar year maximums begin again. Please visit http://snohomishcountywa.gov/983/Medical for more resources.